U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 06 June 2005

CASE NO.: 2003-BLA-6107

In the Matter of

IKIE BRYANT,
Claimant

v.

ARCH OF WEST VIRGINIA,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Ikie Bryant, *pro se*

Mary Rich Maloy, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on October 1, 2001, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed prior claims for benefits on May 7, 1973, August 21, 1974, July 1, 1986, February 25, 1987 and December 10, 1993. (Director's Exhibit ("DX") 1). The 1993 claim was denied because the evidence failed to establish Mr. Bryant was totally disabled due to pneumoconiosis. Administrative Law Judge Neal adopted the findings of Administrative Law Judges Brown and Tierney that Claimant had coal workers' pneumoconiosis. Administrative Law Judge Neal found, however, that the pneumoconiosis did not arise out of coal mine employment and that Claimant was not totally disabled due to a pulmonary impairment. The Benefits Review Board issued a decision, dated September 19, 2000, affirming Judge Neal's Decision and Order Denying Benefits. (DX 1).

The claimant filed his current claim for benefits on October 1, 2001. (DX 3). On April 3, 2003, the claim was denied by the district director because the evidence failed to establish the elements of entitlement that Mr. Bryant had coal workers' pneumoconiosis and was totally disabled due to pneumoconiosis. The District Director found six years of coal mine employment. (DX 27). On April 8, 2003, the claimant requested a hearing before an administrative law judge. On June 26, 2003, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. I was assigned the case on October 4, 2004.

On February 17, 2005, I held a hearing in Charleston, West Virginia, at which the claimant represented himself and the employer was represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Director's exhibits ("DX") 1-34 and Employer's exhibits ("EX") 1-5[2], 7-8, and 12-13 were admitted into the record. On April 12, 2005, Employer's counsel submitted a closing argument.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

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[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[2] Employer's exhibit 3 exceeds the evidentiary limitations of §725.414. At the hearing, I found good cause for admitting Dr. Altmeyer's supplemental report contained in Employer's exhibit 3. The remainder of Employer's exhibit 3 is excluded from evidence for exceeding the evidentiary limitations.

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether there has been a change in an applicable element of entitlement upon which the order denying the prior claim became final?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 8 years and 4 months. Mr. Bryant began working in the mines in the 1960's and ceased mine work in 1982. During that time, Mr. Bryant was off work for about 8 years, due to a back injury. (DX 1; 4).

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on October 1, 2001. (DX 3). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[3]

Arch of West Virginia is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart G for claims filed on or after Jan. 19, 2001, Part 725 of the Regulations. (DX 1).

D. Dependents

The claimant has no dependents for purposes of augmentation of benefits under the Act. Claimant married Linda Jane Bryant on November 12, 1954. The parties divorced on March 19, 1985. Mr. Bryant's ex-wife died in 1990. (DX 9, 10; TR 18).

E. Personal, Employment and Smoking History

The claimant was born on June 26, 1932. (DX 3). The Claimant's last position in the coal mines was that of a shuttle car operator. Mr. Bryant also operated a bridge carrier. (DX 3; TR 15). The claimant, as part of his duties, was required to haul coal from the mine to the belt line. (DX 1).

There is evidence of record that the claimant's respiratory disability is due, in part, to his history of cigarette smoking. The evidence is conflicting concerning the miner's smoking

[3] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

history. However, I find he smoked at least thirty years. At the February 17, 2005 hearing, Claimant testified that he does not smoke and that he never did smoke. (TR 19). After reviewing the evidence, I do not find this statement to be credible. At an October 24, 1996 hearing before Administrative Law Judge Neal, Claimant testified that he stopped smoking in 1988. (DX 1; October 24, 1996 Transcript, p. 34). Claimant communicated to various doctors that he began smoking at age 20 and quit in the 1980's. The record contains evidence that Claimant may have smoked as late as 1995. Thus, I find that the claimant began smoking in his 20's and quit in the late 1980's.

II. Medical Evidence[4]

The following is a summary of the evidence submitted since the final denial of the prior claim.

A. Chest X-rays[5]

In the miner's current claim for benefits, there were five readings of three X-rays, taken on November 15, 2001, July 23, 2003, and November 24, 2003. (DX 17, 18; EX 1, 2, 5). One is positive, by Dr. Ranavaya, a B-reader.[6] Three are negative, by three physicians, Drs. Wheeler, Willis and Zaldivar, all of whom are either B-readers, Board-certified in radiology, or both. Dr. Binns provided a quality-only reading of the November 15, 2001 X-ray.

Chest X-ray evidence submitted in the miner's current claim for benefits:

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 5	11/24/2003 12/1/2003	Dr. Willis	B, BCR	1		No acute disease. No evidence of occupational pneumoconiosis.
EX 2	7/23/2003 9/1/2003	Dr. Zaldivar	B, BCP(I)	2		No parenchymal abnormalities consistent with pneumoconiosis. Emphysema.
EX 1	11/15/2001	Dr. Wheeler	B, BCR	2		No parenchymal

[4] *Dempsey v. Sewell Coal Co. & Director, OWCP*, 23 B.L.R. 1-47 (2004), BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). BRB upheld regulatory limitations on the admissibility of medical evidence, under the new 2001 regulations, i.e., 20 C.F.R. Sections 725.414 and 725.456(b)(1).

[5] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[6] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
	7/1/2003					abnormalities consistent with pneumoconiosis. Moderate bullous emphysema.
DX 17	11/15/2001 11/15/2001	Dr. Ranavaya	B	1	1/0	s/p all zones. Bullous emphysema.
DX 18	11/15/2001 1/22/2002	Dr. Binns	B, BCR	2		Quality only Reading.

Chest X-ray evidence submitted in the miner's first five claims for benefits: (DX 1).

Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
3/29/1995 10/1/1995	Dr. Wiot	B, BCR	2		No abnormalities consistent with pneumoconiosis.
3/29/1995 9/22/1995	Dr. Shipley	B, BCR	1		No abnormalities consistent with pneumoconiosis.
3/29/1995 9/27/1995	Dr. Spitz	B, BCR	1		No abnormalities consistent with pneumoconiosis.
3/29/1995 8/13/1995	Dr. Zaldivar	B, BCP(I)	1		No abnormalities consistent with pneumoconiosis.
2/4/1994 3/21/1995	Dr. Spitz	B, BCR	1		No abnormalities consistent with pneumoconiosis.
2/4/1994 3/9/1995	Dr. Wiot	B, BCR	1		No abnormalities consistent with pneumoconiosis.
2/4/1994 3/6/1995	Dr. Shipley	B, BCR	1		No CWP.
2/4/1994 3/14/1994	Dr. Cole	B, BCR	1		No abnormalities consistent with pneumoconiosis. Emphysema.
2/4/1994 3/1/1994	Dr. Francke	B, BCR	1		No abnormalities consistent with pneumoconiosis. Emphysema.
2/4/1994 2/4/1994	Dr. Ranavaya	B	1	1/0	s/t, lower four zones.
5/9/1990 6/26/1990	Dr. Gogineni	B, BCR	1		Emphysematous changes. No definite evidence of pneumoconiosis.
5/9/1990 5/17/1990	Dr. Zaldivar	B, BCP(I)	1		No parenchymal abnormalities consistent with pneumoconiosis. Bullae emphysema.
10/9/1989 6/20/1990	Dr. Duncan	B, BCR	1		Emphysema. No evidence of occupational pneumoconiosis.

Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
10/9/1989 6/19/1990	Dr. Wershba	B, BCR	1		No evidence of occupational pneumoconiosis. Findings consistent with bullous emphysema.
10/9/1989 6/18/1990	Dr. Gogineni	B, BCR	1		COPD. Emphysema. No evidence of pneumoconiosis.
10/9/1989 11/2/1989	Dr. Speiden	B, BCR	1	1/0	The lungs show minimal peripheral parenchymal densities which could be consistent with simple pneumoconiosis.
10/14/1987 10/14/1987	Dr. Pelaez			1/2	19 years of coal mine employment. Both lungs are emphysematous. Early pulmonary emphysema.
7/13/1987 12/6/1987	Dr. Gaziano	B	2		No parenchymal abnormalities consistent with pneumoconiosis.
3/12/1987 6/5/1990	Dr. Hayes	B, BCR	2		No parenchymal changes to suggest pneumoconiosis.
3/12/1987 6/4/1990	Dr. Abramowitz	B, BCR	1	0/1	COPD. No conclusive evidence of pneumoconiosis.
3/12/1987 3/13/1987	Dr. Al-Asbani	B, BCR	1	1/0	"s" type. All zones. Mild changes of pneumoconiosis.
3/12/1987 3/12/1987	Dr. Gaziano	B	1		No parenchymal abnormalities consistent with pneumoconiosis.
9/30/1986 3/4/1991	Dr. Abramowitz	B, BCR	1		No evidence of pneumoconiosis.
9/30/1986 3/4/1991	Dr. Duncan	B, BCR	1		No evidence of pneumoconiosis.
9/30/1986 2/28/1991	Dr. Hayes	B, BCR	2		No evidence of pneumoconiosis.
9/30/1986 9/30/1986	Dr. Al-Asbani	B, BCR			Hyperaeration and chronic lung changes. No acute infiltrates.
9/13/1985 9/13/1985	Dr. Duncan	B, BCR	1		No parenychmal abnormalities consistent with pneumoconiosis.
5/3/1979 5/3/1979	Dr. Pelaez			1/2	15 years of coal mine employment. Scattered rounded opacities throughout the lung field.
5/27/1977 5/27/1977	Dr. Pelaez			2/1	20 years of coal mine employment. Scattered rounded opacities throughout the lung field.
4/30/1974 4/30/1974	Dr. Pelaez				Simple pneumoconiosis. Mild pulmonary emphysema.
12/7/1973	Dr. Pelaez			1/1	Few rounded opacities throughout

Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
12/7/1973					the lung fields.
11/15/1973 11/15/1973	Dr. Valle			1/0	Moderate generalized pulmonary emphysema. Minimal degree of pneumoconiosis.
6/15/1973 6/15/1973	Dr. Pelaez			1/0	15 years of coal mine employment. Lung fields were hyperlucent. There's an increase in bronchial markings. Small rounded opacities throughout the lung fields. Pulmonary emphysema.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Pulmonary function study evidence submitted in the miner's current claim for benefits:

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Tracings	Comprehen-sion Coopera-tion	Qualify * Conform **	Dr.'s Impression/ Ratio values
Dr. Crisalli 11/24/2003 EX 4	71 71.5"	1.37	36	3.42	Yes	Good Good	Yes Yes	The miner's FEV1/FVC ratio equals 40%.

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Tracings	Comprehen-sion Coopera-tion	Qualify * Conform **	Dr.'s Impression/ Ratio values
Dr. Crisalli 11/24/2003 EX 4 Post-Bron	71 71.5"	1.70		4.06	Yes	Good Good	Yes Yes	The miner's FEV1/FVC ratio equals 42%.
Dr. Zaldivar 7/23/2003 EX 2	71 72"	1.50		4.22	Yes		Yes Yes	Severe reversible obstruction. The miner's FEV1/FVC ratio equals 35%.
Dr. Zaldivar 7/23/2003 EX 2 Post-Bron	71 72"	1.71		4.82	Yes		Yes Yes	The miner's FEV1/FVC ratio equals 35%.
Dr. Ranavaya 4/2/2002 DX 15	69 73"	1.87		3.74	Yes	Good Good	Yes Yes	The miner's FEV1/FVC ratio equals 50%.
Dr. Ranavaya 4/2/2002 DX 15 Post-Bron	69 73"	2.09		4.15	Yes	Good Good	Yes Yes	The miner's FEV1/FVC ratio equals 50%.
Dr. Ranavaya 11/15/2001 DX 14	69 73"	1.75		3.49	Yes	Good Fair	Yes No	The miner's FEV1/FVC ratio equals 50%.
Dr. Ranavaya 11/15/2001 DX 14 Post-Bron	69 73"	1.83		3.62	Yes	Good Fair	Yes No	The miner's FEV1/FVC ratio equals 50%.

Pulmonary function studies submitted in the miner's first five claims for benefits: (DX 1)

Physician Date	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify Conform	Dr.'s Impression/ Ratio values
Dr. Zaldivar	62 71"	2.00	70	4.76	Yes		Yes Yes	

Physician Date	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify Conform	Dr.'s Impression/ Ratio values
3/29/1995								
Dr. Zaldivar 3/29/1995 Post-Bron	62 71"	1.82		4.19	Yes		No Yes	
Dr. Ranavaya 3/4/1994[7]	61 73"	2.16	80.1	3.87	Yes	Fair Fair	Yes Yes	
Dr. Ranavaya 2/4/1994[8]	61 73"	1.97	87.9	3.59	Yes	Good Good	Yes Yes	Miner became dizzy and could not complete post bronchodilator Test.
Dr. Zaldivar 5/9/1990	57 72"	2.46	93	4.93	Yes		Yes Yes	FEV1/FVC ratio equals 49%.
Dr. Zaldivar 5/9/1990 Post-Bron	57 72"	2.53	104	5.00	Yes		Yes Yes	FEV1/FVC ratio equals 51%.
Dr. Rasmussen 10/9/1989	57 72"	2.66	104	5.16	No	Good Good	Yes No	FEV1/FVC ratio equals 51%.
Dr. Rasmussen 10/9/1989 Post-Bron	57 72"	2.70	108	5.01	No	Good Good	Yes No	FEV1/FVC ratio equals 54%.
Dr. Sathish 4/26/1989	56 73"	2.12	93.44	3.54	Yes		No Yes	
Dr. Patel 7/23/1987	55 73"	2.64	99	4.47	No		No No	Moderate COPD.
Dr. Patel 7/23/1987 Post-Bron	55 73"	3.06	100	4.82	No		No No	
Dr. Acosta 3/11/1987	54 73"	2.72	105	4.05	No	Good Good	No No	
Dr. Velasco	54 73"	2.07	57.1	4.10	No	Good Good	Yes No	

[7] Dr. Gaziano reviewed this study and concluded that the vents are not acceptable due to less than optimal effort, cooperation and comprehension. (DX 1).

[8] Dr. Gaziano reviewed this study and concluded that the vents are not acceptable due to less than optimal effort, cooperation and comprehension. (DX 1).

Physician Date	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify Conform	Dr.'s Impression/ Ratio values
10/2/1986								
Dr. Crisalli 9/13/1985	53 73"	3.13	71	5.37	Yes	Good Good	No Yes	Moderate obstruction to airflow.
Dr. Pelaez 5/3/1979	46 73"	1.50	63		Yes	Good Good	Yes Yes	

*A "**qualifying**" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Dr. Gaziano reviewed Dr. Ranavaya's November 15, 2001 pulmonary function study. Dr. Gaziano concluded that the vents are not acceptable due to less than optimal effort, cooperation and comprehension. (DX 14). Dr. Gaziano also reviewed Dr. Ranavaya's April 2, 2002 pulmonary function study. Dr. Gaziano concluded that the vents of the April 2, 2002 test are acceptable. (DX 15).

For a miner of the claimant's height of 72.4 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 2.07 for a male 71 years of age.[9] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.67 or an MVV equal to or less than 83; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ration requirement remains constant.

Height	Age	FEV_1	FVC	MVV
71.5"	71	2.01	2.59	80
72"	71	2.04	2.63	82
73"	69	2.16	2.78	87

C. Arterial Blood Gas Studies[10]

[9] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 72.4" here, his average reported height.

[10] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Blood gas studies submitted in the miner's current claim for benefits:

Date **Ex. #**	**Physician**	**PCO2**	**PO2**	**Qualify**	**Physician Impression**
11/24/2003 EX 4	Dr. Crisalli	40	68	No	
7/23/2003 EX 2	Dr. Zaldivar	41 41*	67 60*	No Yes	Exercise stopped due to shortness of breath. Blood gases showed hypoxemia at rest and with exercise.
11/15/2001 DX 13	Dr. Ranavaya	43 39*	64 81.8*	No No	

Arterial blood gas studies submitted in the miner's first five claims for benefits: (DX 1).

Date	**Physician**	**PCO2**	**PO2**	**Qualify**
3/29/1995	Dr. Zaldivar	35	75	No
2/4/1994	Dr. Ranavaya	35.3	68.9	No
5/9/1990	Dr. Zaldivar	38	69	No
10/9/1989	Dr. Rasmussen	38 37*	80 72*	No No
3/11/1987	Dr. Acosta	41.3 41.1*	83.8 101.2*	No No
9/30/1986	Dr. Valesco	34	93	No
9/13/1985	Dr. Crisalli	38.5 38.7*	84.9 92.8	No No

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

D. Physicians' Reports[11]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner

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20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

[11] *Dempsey v. Sewell Coal Co. & Director, OWCP*, 23 B.L.R. 1-47 (2004), BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Crisalli is Board-certified in internal medicine and pulmonary disease. His report, dated December 22, 2003, based upon his examination of the claimant, on November 24, 2003, notes 13 years of coal mine employment, as communicated to him by the Claimant, and that Claimant stopped smoking twenty years prior. Dr. Crisalli described the claimant's complaints as shortness of breath, cough with sputum production, orthopnea and paroxysmal nocturnal dyspnea. (EX 4).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Crisalli diagnosed emphysema, chronic bronchitis, obstructive sleep apnea, hypertension, coronary artery disease and gastroesophageal reflux disease. Dr. Crisalli found a "moderate degree of obstructive respiratory impairment with a severe degree of air trapping." Dr. Crisalli found the Claimant disabled due to bullous emphysema. He opined that Mr. Bryant's emphysema is in no way related to his coal dust exposure. (EX 4).

Dr. Crisalli was deposed by Employer's counsel on February 7, 2005. (EX 13). Dr. Crisalli examined Mr. Bryant in 1986 and in 2003. Dr. Crisalli testified that Mr. Bryant had complaints of shortness of breath and cough with sputum production. (EX 13, p. 10). Dr. Crisalli stated that Mr. Bryant had ten to thirteen years of coal mine employment. He testified that, in a susceptible individual, such coal mine employment can be significant enough to cause coal dust related disease. He opined that Mr. Bryant does not have a coal dust related disease. (EX 13, p. 10).

Dr. Crisalli noted some inaccuracies in Claimant's smoking history. During the 2003 exam, Mr. Bryant communicated to Dr. Crisalli that he stopped smoking about twenty years prior. During the 1985 examination, Mr. Bryant communicated to Dr. Crisalli that he smoked up to a pack of cigarettes per day for twenty years. Dr. Crisalli also noted that various hospital records listed smoking histories of forty years. After reviewing all the evidence, Dr. Crisalli determined that Mr. Bryant has a "very heavy smoking history." (EX 13, pp. 11-13).

Based on his 2003 examination of Mr. Bryant, Dr. Crisalli noted that the chest wall motion was diminished and the breath sounds were diminished. He explained that this is consistent with emphysema. Dr. Crisalli concluded that Mr. Bryant has bullous emphysema. He explained that bullous emphysema is not found in individuals with coal workers' pneumoconiosis. (EX 13, pp. 17-19).

Dr. Crisalli stated that Mr. Bryant's pulmonary function study shows a moderate obstruction to air flow and a moderate degree of air trapping. He found no restrictive defect. Dr. Crisalli explained that the moderate obstruction to air flow is consistent with emphysema and the air trapping is typical of emphysema. Mr. Bryant had significant reversibility with

bronchodilators. (EX 13, pp. 19-20). The blood gas study performed showed a mild degree of hypoxemia. (EX 13, p. 22). Dr. Crisalli concluded that Mr. Bryant has a totally disabling pulmonary impairment because of his bullous emphysema which is related to his tobacco smoke exposure. (EX 13, p. 28).

Dr. Robert Altmeyer is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary diseases. He provided a consultation report, based upon his review of the medical records of the claimant, dated November 13, 2003. (EX 3). Dr. Altmeyer concluded that Claimant does not have coal workers' pneumoconiosis. Dr. Altmeyer did find a significant respiratory impairment due to bullous emphysema, chronic bronchitis and a component of asthma. Dr. Altmeyer noted that the bullous emphysema is caused by cigarette smoking. (EX 3).

Dr. Altmeyer disagrees with Dr. Ranavaya's conclusion regarding pneumoconiosis, dated November 15, 2001. Dr. Ranavaya found "s" type opacities on a chest X-ray. Dr. Altmeyer argues "I would point out that 's' type opacities, which are irregular opacities, are not known to be the primary opacities which occur with coal workers' pneumoconiosis; therefore, Dr. Ranavaya's reading of the X-ray is not consistent with coal workers' pneumoconiosis, a finding contrary to his report." (EX 3).

Dr. Altmeyer determined that Mr. Bryant is totally and permanently disabled to such an extent that he would be unable to do his regular coal mining work. Dr. Altmeyer contributed Claimant's pulmonary impairment to his "cigarette induced chronic obstructive pulmonary disease." (EX 3).

Dr. George Zaldivar is a B-reader and is Board-certified in pulmonary diseases, internal medicine, sleep disorder and critical care medicine. Dr. Zaldivar examined the Claimant on July 23, 2003. The miner communicated to Dr. Zaldivar that he worked in the coal mines for ten years and quit smoking in the 1980's. Dr. Zaldivar described the claimant's symptoms as shortness of breath, wheezing, and morning cough productive of sputum. (EX 2).

Based on arterial blood gases, a pulmonary function study, and a chest X-ray, Dr. Zaldivar concluded that there is no evidence to justify a diagnosis of coal workers' pneumoconiosis. Dr. Zaldivar diagnosed bullous emphysema with a small component of asthma. He determined that the emphysema was caused by cigarette smoking. (EX 2).

Dr. Zaldivar concluded that "from the pulmonary standpoint, Mr. Bryant is incapable of performing his usual coal mining work." Dr. Zaldivar stated that Claimant's pulmonary impairment is not related to his coal mining employment. (EX 2).

Dr. Zaldivar was deposed by Employer's counsel, on December 22, 2003. (EX 7). Dr. Zaldivar testified that he examined Mr. Bryant in 1990, 1995 and again in 2003. (EX 7, p. 5). The Claimant communicated to Dr. Zaldivar that he has shortness of breath and needs to keep his bed elevated due to breathing problems. Dr. Zaldivar stated that neither coal workers' pneumoconiosis nor emphysema requires the head of the bed to be elevated; the elevation is more related to congestive heart failure or asthma. Dr. Zaldivar stated that Mr. Bryant was using a proventil inhaler. Dr. Zaldivar explained that the proventil inhaler is an albuterol medication

for immediate relief. He explained that such medication will not help someone with coal workers' pneumoconiosis or emphysema. (EX 7, p. 6).

Dr. Zaldivar testified that Mr. Bryant's smoking history was not accurate. The Claimant communicated to Dr. Zaldivar that he quit smoking in 1988. Dr. Zaldivar, however, states that a 1995 carbon monoxide level test shows that the Claimant was still smoking in 1995. Dr. Zaldivar further stated that the carbon monoxide level displayed a smoker of a pack of cigarettes a day. Mr. Bryant stated that he smoked two or three cigarettes a day. (EX 7, p. 7). Mr. Bryant did not have the level of a smoker at the 2003 carbon monoxide test. (EX 7, p. 11).

Mr. Bryant communicated to Dr. Zaldivar that he worked in the coal mines for ten years, but that the Department of Labor only recognized six years. Dr. Zaldivar stated "[s]ix years or ten years of work in the coal mines is less than what is expected to begin to cause any kind of lung problems from coal workers' pneumoconiosis, but anything is possible, of course." (EX 7, pp. 7-8).

As part of his examination of the Claimant, Dr. Zaldivar performed a pulmonary function study. Dr. Zaldivar stated that the pulmonary function study showed a combination of asthma and emphysema. He also found a severe airway obstruction. Dr. Zaldivar noted improvement characteristic of bronchospasm. The test also showed a low diffusing capacity. Dr. Zaldivar stated that the low diffusion is a result of emphysema. (EX 7, pp. 9-10).

Based on the breathing tests and the cardiopulmonary stress test, Dr. Zaldivar found the Claimant has a disabling pulmonary impairment due to emphysema. (EX 7, p. 13). Dr. Zaldivar explained that the bullae present radiographically reveals the presence of emphysema; it is not a manifestation of coal workers' pneumoconiosis. Dr. Zaldivar testified "there is no evidence of pneumoconiosis radiographically, which means that insufficient dust has been retained within the lungs to have caused damage to the airways." Dr. Zaldivar found bullae evidence in the 1990 and 1995 X-rays. He testified that "the X-ray of 2003 also shows a hyperinflation, but I couldn't identify the bullae." (EX 7, p. 14).

Dr. Sathishchandra Rao submitted a letter on behalf of the Claimant, dated February 26, 2003. (DX 26). Mr. Bryant has a check-up with Dr. Rao "every couple of months." Dr. Rao treats Claimant for his COPD, pneumoconiosis, hypertension, colon cancer and coronary artery disease. Dr. Rao notes over 20 years of coal dust exposure. He further notes that Claimant has no history of smoking. Dr. Rao advised Claimant to use a Combivent inhaler four times a day. Dr. Rao states that Claimant has shortness of breath upon minimal exertion. Based on his examinations of the Claimant, Dr. Rao concluded "the patient has moderate to severe chronic obstructive pulmonary disease secondary to working in the coal mines underground for over 10 years." (DX 26).

Dr. Ranavaya, whose qualifications are not in the record, performed the Department of Labor examination. His report, based on his November 15, 2001 examination, notes 22 years of coal mine employment and a 10-year smoking history. Dr. Ranavaya notes that Claimant has been chewing tobacco since 1947. Claimant smoked ½ pack of cigarettes per day from 1978 through 1988. (DX 12). Dr. Ranavaya notes that Claimant's medical history includes pneumonia, attacks of wheezing, arthritis, heart disease, colon cancer and high blood pressure.

He describes Claimant's symptoms as daily sputum, nightly wheezing, dyspnea, hemoptysis, 2 pillow orthopnea and paroxysmal nocturnal dyspnea. (DX 12).

Based on arterial blood gases, a pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed pneumoconiosis, bullous emphysema, coronary artery disease, and hypertension. (DX 12).

He opined that the claimant's pneumoconiosis was related to his coal dust exposure and his bullous emphysema was related to his cigarette smoking history. Dr. Ranavaya concluded that Claimant has a "moderate pulmonary impairment which would prevent him from performing his last coal mining employment on a sustained basis." Dr. Ranavaya stated that Claimant's pulmonary impairment is due to both his pneumoconiosis and bullous emphysema. (DX 12).

The following is a summary of the physician opinions submitted in the miner's first five claims for benefits.

Dr. Altmeyer submitted a consultation report, dated April 25, 1991. After reviewing numerous positive and negative chest X-rays, Dr. Altmeyer concluded that the miner does not have coal workers' pneumoconiosis. He noted that the films show typical changes of upper lobe pulmonary emphysema. He explained that the presence of pulmonary emphysema is confirmed by the presence of a low diffusing capacity. Dr. Altmeyer found the radiographic evidence and pulmonary studies consistent with the affects of long germ cigarette smoking.

Based upon his review of the pulmonary function studies, Dr. Altmeyer concluded that Mr. Bryant has a moderate degree of airways obstruction due to chronic bronchitis and also due to pulmonary emphysema. (DX 1).

Dr. Altmeyer submitted a report, dated December 3, 1996, based on a review of Dr. Rao's conclusions and deposition. Dr. Altmeyer states that Dr. Rao seems to imply that pneumoconiosis and emphysema are the same. Dr. Altmeyer found that Mr. Bryant's pulmonary function studies are consistent with cigarette induced bullous emphysema. Dr. Altmeyer explains that a finding of bullous emphysema radiographically is not consistent with coal workers' pneumoconiosis. As such, Dr. Altmeyer disagrees with Dr. Rao's belief that the claimant's emphysema is evidence of pneumoconiosis. (DX 1).

The record contains a letter from Dr. Rao, dated November 30, 1994. He states that he has treated the miner for 10 years for pneumoconiosis, hypertension, old myocardial infarction and coronary artery disease. Dr. Rao also notes that a CT scan of the chest showed bullous emphysema. He prescribed two inhalers for Mr. Bryant. Dr. Rao concludes "patient has moderate to severe black lung from working in the coal mines." (DX 1).

Dr. Rao submitted a letter, dated November 9, 1995, stating that he treats Mr. Bryant for coal workers' pneumoconiosis, hypertension, old myocardial infarction, and coronary artery disease. He explains that the miner's chest X-ray and CT scan show bullous emphysema. Dr. Rao opined that Mr. Bryant has moderate to severe black lung. (DX 1). Dr. Rao submitted a second letter, dated September 17, 1996, repeating his findings. (DX 1).

On May 9, 1990, Dr. Zaldivar examined Mr. Bryant. Dr. Zaldivar listed a ten year coal mine employment. Dr. Zaldivar noted that "Mr. Bryant has a very significant smoking history which is sufficient in itself to produce emphysema." The carboxyhemoglobin level test taken during the examination showed that Mr. Bryant was a current smoker. Dr. Zaldivar explained that the objective testing shows an airway obstruction and low diffusing capacity consistent with emphysema. He stated that the diffusing capacity is low because the lung tissue has been damaged by cigarette smoking.

Based on his examination, Dr. Zaldivar concluded that Mr. Bryant does not have coal workers' pneumoconiosis. He found Mr. Bryant to suffer from emphysema due to smoking. Dr. Zaldivar opined that, from a pulmonary standpoint, Mr. Bryant could perform his last job as a shuttle car operator. (DX 1).

On May 29, 1991, Dr. Zaldivar submitted a supplemental report after reviewing additional evidence. Dr. Zaldivar did not alter his opinion after reviewing the miner's additional medical evidence. Dr. Zaldivar diagnosed Mr. Bryant with emphysema due to smoking. (DX 1).

Dr. Zaldivar submitted a report, dated August 14, 1995, based on his March 29, 1995 examination of the Claimant. Dr. Zaldivar listed the miner's symptoms as shortness of breath, occasional ankle swelling, cough productive of sputum, and wheezing. Based on the objective testing performed and a review of Claimant's medical history, Dr. Zaldivar found evidence of bullae and emphysema. He did not find any evidence of pneumoconiosis. Dr. Zaldivar concluded that the bullous emphysema was caused by Mr. Bryant's smoking habit. He noted that the carboxyhemoglobin level was that of a smoker. Dr. Zaldivar further concluded: "Mr. Bryant has a very significant pulmonary impairment which is the result of emphysema. From a pulmonary standpoint, Mr. Bryant will not be able to perform his usual coal mining work because of this emphysema which he has acquired from smoking." (DX 1).

Dr. Zaldivar submitted an additional report, dated November 26, 1996, after reviewing a deposition of Dr. Sathish Rao. During his deposition, Dr. Rao states that a diagnosis of bullous emphysema is the same as a diagnosis of coal workers' pneumoconiosis. Dr. Zaldivar explained that coal workers' pneumoconiosis causes focal emphysema; not bullous emphysema. As such, Dr. Zaldivar disagrees with Dr. Rao's diagnosis. (DX 1).

Dr. Ranavaya performed the Department of Labor examination on February 4, 1994. Dr. Ranavaya noted a 22 year coal mine employment and a 10 year smoking history at ½ pack per day. Dr. Ranavaya listed the miner's symptoms as sputum, wheezing, dyspnea, cough, chest pain, orthopnea and paroxysmal nocturnal dyspnea.

Based upon his examination, Dr. Ranavaya diagnosed the claimant with pneumoconiosis, coronary artery disease, and hypertension. Dr. Ranavaya concluded that the miner has a moderate pulmonary impairment due to pneumoconiosis. (DX 1).

Dr. Rasmussen examined Mr. Bryant on October 9, 1989. Dr. Rasmussen lists the miner's symptoms as dyspnea, chronic productive cough, wheezing, orthopnea, paroxysmal nocturnal dyspnea, and occasional ankle swelling. In regards to cigarette smoking, Dr. Rasmussen noted: "The patient states that he smoked 1 pack of cigarettes a day for

approximately 20 years. He is now smoking ½ pack of cigarettes a day for the past year." Dr. Rasmussen listed a 14 year coal mine employment.

Dr. Rasmussen diagnosed the Claimant with coal workers' pneumoconiosis. Based upon his examination, Dr. Rasmussen concluded that Mr. Bryant's degree of impairment would render him totally disabled for resuming his former coal mine employment. Dr. Rasmussen stated that the miner's disability is due to cigarette smoking and coal dust exposure. (DX 1).

The evidence contains Logan General Hospital records, dated August 12, 1988. Mr. Bryant entered the hospital with chest pain and left jaw pain. Under past medical history, the hospital listed: "significant for HPN, pneumoconiosis, duodenal ulcer disease." Under impression, the hospital listed: "(1) Angina, R/O MI; (2) HPN; and (3) Pneumoconiosis." The records contain no explanation for the mention of pneumoconiosis. (DX 1).

On March 11, 1987, Dr. Acosta examined the Claimant for the Department of Labor. Dr. Acosta noted the following in the miner's health history: frequent colds, pneumonia, pleurisy, attacks of wheezing, arthritis, heart disease, cancer, high blood pressure, and heart problems. Dr. Acosta noted that the miner smoked one pack of cigarettes per day for ten years. He listed the Claimant's present symptoms as cough, sputum production, wheezing, dyspnea, chest pain, orthopnea, paroxysmal nocturnal dyspnea and ankle edema. Based on his examination, Dr. Acosta diagnosed coal workers' pneumoconiosis. Dr. Acosta made no statements regarding disability. (DX 1).

Dr. Crisalli examined the Claimant on September 13, 1985. Mr. Bryant communicated to Dr. Crisalli that he has been working in the coal mines for ten years. He also stated that he has been smoking a ½ pack of cigarettes per day for twenty years. Dr. Crisalli listed the miner's complaints as dyspnea, cough productive of sputum, chest pain, two pillow orthopnea, paroxysmal nocturnal dyspnea and ankle edema.

Based on a pulmonary function study, blood gas study and a chest X-ray, Dr. Crisalli found no evidence of pulmonary disease. Dr. Crisalli noted a mild obstruction to airflow due to his heavy smoking history. Dr. Crisalli found no coal dust related impairment. He also concluded that the miner is not disabled. (DX 1).

A report by Dr. Lesaca was submitted in one of the miner's prior claims for benefits. Dr. Lesaca lists his medical specialties as general practice and obstetrics and gynecology. Dr. Lesaca completed a Social Security Administration Medical Report form. Dr. Lesaca examined Mr. Bryant on December 19, 1973. His report notes 15 years of coal mine employment. Dr. Lesaca noted the miner has had a significant cough beginning five years prior to the examination. He noted that the miner has shortness of breath upon exertion. Dr. Lesaca diagnosed pneumoconiosis and pulmonary emphysema. Dr. Lesaca relied on a chest X-ray and pulmonary function study performed at Guyan Valley Hospital. These studies were not attached to the report. Under Other Remarks, Dr. Lesaca wrote "disabled." (DX 1).

Dr. Borbely performed a psychological evaluation of Mr. Bryant on April 18, 1974. Dr. Borbely noted that Mr. Bryant completed only the second grade of school and cannot read or write. Dr. Borbely diagnosed Claimant with latent schizophrenia. She notes "[s]ince his

retirement, he has been losing ground quite rapidly, and because of his limited, or one might say lack of, resources, it is impossible to believe that he will ever be able to return to any form of employment." (DX 1).

The record contains notes from Dr. Pelaez at the Logan Specialist Medical Clinic. The notes are not dated. Dr. Pelaez stated "Ikie Bryant is a 41 year old white male patient who came in for an internist examination complaining of chest pain and stomach pain." Mr. Bryant communicated to Dr. Pelaez that he worked in the coal mines for 15 years and noticed shortness of breath about 4 to 5 years prior. He also told Dr. Pelaez that he smoked ½ pack of cigarettes per day for "several years." Dr. Pelaez diagnosed simple pneumoconiosis and pulmonary emphysema. No objective test results were attached to this report. Dr. Pelaez also stated that the miner was not totally disabled. (DX 1).

III. Claimant's Testimony

Mr. Bryant testified at the February 17, 2005 hearing. Mr. Bryant began working with Buffalo Mining Company in 1968. In 1970, he had to quit working due to a back injury and did not return to the mines for eight or nine years. Mr. Bryant's duties in the coal mine included running the shuttle car. (TR 14). Mr. Bryant testified that he cannot perform his previous coal mining job due to his difficulty breathing. (TR 15).

Mr. Bryant stated that his shortness of breath began around 1997. His difficulties have progressed to the point that he cannot lay flat on his back at night. Mr. Bryant uses oxygen in his home. He can walk about 20 feet and has difficulty climbing stairs. (TR 16). Mr. Bryant had two operations for colon cancer. On cross-examination, Mr. Bryant testified that he does not smoke cigarettes and that he never has smoked cigarettes. (TR 20).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986).

Since this is the claimant's sixth claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations.[12] Although the new regulations

[12] Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067):

dispense with the "material change in conditions" language of the older regulations, the criteria remain similar to the "one-element" standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), which was adopted by the United States Court of Appeals for the Fourth Circuit, in *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). In *Dempsey v. Sewell Coal Co. & Director, OWCP*, 23 B.L.R. 1-47 (June 28, 2004), the Board held that where a miner files a claim for benefits more than one year after the final denial of a previous claim, the subsequent claim must also be denied unless the administrative law judge finds that "one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. Section 725.309(d); *White v. New White Coal Co., Inc.*, 23 B.L.R. 1-1, 1-3 (2004). According to the Board, the "applicable conditions of entitlement" are "those conditions upon which the prior denial was based." 20 C.F.R. Section 725.309(d)(2).

To assess whether a material change in conditions is established, the Administrative Law Judge must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of September 29, 2000, i.e., total disability and disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale,* the Fourth Circuit does not require consideration of the evidence in the prior claim

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(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Sections 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n. 11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits.

The claimant's prior application for benefits was denied because the evidence failed to show that: (1) the pneumoconiosis arose, at least in part, out of coal mine employment; (2) the miner was totally disabled; and (3) the claimant was totally disabled by pneumoconiosis. (DX 1). Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits. As discussed below, I find that a material change has occurred in that I find that the Claimant is now totally disabled due to a pulmonary impairment. As such, I have reviewed the evidence submitted in the five previous claims to determine whether Mr. Bryant is entitled to benefits.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[13] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[14]

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[13] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co*., 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[14] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[15] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[16] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's

[15] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[16] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344(1985); *Melnick v. Consolidation Coal Co. & Director, OWCP,* 16 B.L.R. 1-31, 1-37 (1991).

The most recent X-ray in the record, dated November 24, 2003, was interpreted by a dually-qualified physician as having no evidence of occupational pneumoconiosis. The record contains no other readings of this X-ray. Thus, I find the November 24, 2003 X-ray negative for coal workers' pneumoconiosis.

A B-reader interpreted the July 23, 2003 X-ray has having no parenchymal abnormalities consistent with pneumoconiosis. There are no other interpretations of this X-ray. As such, I also find the July 23, 2003 X-ray negative for coal workers' pneumoconiosis.

The November 15, 2001 X-ray was read by two physicians. A B-reader interpreted the X-ray as positive for pneumoconiosis with a reading of 1/0. A dually-qualified physician interpreted the reading as having evidence of bullous emphysema, but no parenchymal abnormalities consistent with pneumoconiosis. I accord more weight to the opinion of the dually-qualified physician. Thus, I find the November 15, 2001 X-ray as negative for coal workers' pneumoconiosis.

In summary, I find the most recent X-rays, November 24, 2003, July 23, 2003 and November 15, 2001, negative for coal workers' pneumoconiosis. Therefore, I find that the

claimant did not prove coal workers' pneumoconiosis based on chest X-ray evidence submitted in the current claim.

As discussed below, I found Claimant to be totally disabled. Due to the fact that Mr. Bryant has proven a material change in condition, the evidence submitted in the miner's prior claim for benefits must be reviewed to determine if the miner is entitled to benefits. Thirty-four readings of fifteen X-rays were submitted in the miner's five previous claims for benefits.

The March 29, 1995 X-ray was read by four physicians as negative. No positive readings of this X-ray are included in evidence. Thus, I find the March 29, 1995 X-ray negative for pneumoconiosis.

The February 4, 1994 X-ray was read by five dually qualified physicians as negative for pneumoconiosis. One B-reader interpreted the X-ray as positive. Based on the physician qualifications and a majority of the readings being negative, I find the February 4, 1994 X-ray negative for pneumoconiosis.

A May 9, 1990 X-ray was interpreted by two physicians as negative for pneumoconiosis. No positive readings of this X-ray are included in evidence. As such, I find the May 9, 1990 X-ray negative for pneumoconiosis.

The October 9, 1989 X-ray was interpreted by three dually qualified physicians as negative. One dually qualified physician interpreted the X-ray as positive. Based on a majority of the readings being negative, I find the October 9, 1989 X-ray negative for pneumoconiosis.

Dr. Pelaez interpreted the October 14, 1987 X-ray as positive for pneumoconiosis. This is the only reading of the October 14, 1987 X-ray. Dr. Pelaez's qualifications are not in the record. Due to his unknown qualifications, I find that his interpretation is entitled to little weight.

A July 13, 1987 X-ray was interpreted by a B-reader as negative for pneumoconiosis. As this is the only interpretation of the July 13, 1987 X-ray, I find the July 13, 1987 X-ray negative for pneumoconiosis.

The March 12, 1987 X-ray was interpreted by two dually qualified physicians and one B-reader as negative. One dually qualified physician interpreted the X-ray as positive. Based on a majority of the readings being negative, I find the March 12, 1987 X-ray negative for pneumoconiosis.

The September 30, 1986 X-ray was interpreted by four dually qualified physicians as negative for pneumoconiosis. As these are the only readings included in the record, I find the September 30, 1986 X-ray negative for pneumoconiosis. Additionally, the September 13, 1985 X-ray was interpreted by a dually qualified physician as negative. There are no other readings in the record. Thus, I find the September 13, 1985 X-ray negative for pneumoconiosis.

Dr. Pelaez provided positive interpretations of X-rays dated June 15, 1973, December 7, 1973, April 30, 1974, May 27, 1977, and May 3, 1979. No other interpretations of these X-rays are included in the record. As noted above, the qualifications of Dr. Pelaez are not in the record. As such, I accord little weight to his interpretations. Additionally, a November 15, 1973 X-ray

was interpreted by Dr. Valle. Dr. Valle's qualifications are not in the record. As such, I also accord his interpretation little weight. Furthermore, these six X-rays are more than 30 years old. Pneumoconiosis is a progressive disease. Thus, I find that the more recent X-rays of record are most persuasive.

In summary, I find the September 13, 1985, September 30, 1986, March 12, 1987, July 13, 1987, October 9, 1989, May 9, 1990, February 4, 1994 and March 29, 1995 X-rays negative for pneumoconiosis. I find the June 15, 1973, November 15, 1973, December 7, 1973, April 30, 1974, May 27, 1977, May 3, 1979 and October 14, 1987 X-rays entitled to very little weight.

After reviewing all of the X-rays in the record, I find that the overwhelming majority of X-rays are negative for pneumoconiosis. As such, I find that Mr. Bryant has not proven pneumoconiosis based on X-ray evidence.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[17] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Altmeyer and Zaldivar above Drs. Crisalli, Ranavaya and Rao.

Dr. Altmeyer reviewed the Claimant's medical records and concluded that the Claimant does not have coal workers' pneumoconiosis. Dr. Altmeyer stated that the evidence shows bullous emphysema caused by smoking. Dr. Altmeyer provided a persuasive reason for disagreeing with Dr. Ranavaya's finding of coal workers' pneumoconiosis. Dr. Altmeyer noted that Dr. Ranavaya's finding relied on an X-ray showing "s" type opacities, not typical of CWP, and that the X-ray was interpreted as negative by a dually-qualified physician. I find that Dr. Altmeyer provided a reasoned opinion based on the objective evidence of record. Based on his qualifications and reasoned opinion, I find that Dr. Altmeyer's opinion is entitled to more weight than Drs. Ranavaya and Rao.

[17] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…"

Dr. Zaldivar also diagnosed bullous emphysema and found that the evidence was not sufficient to justify a diagnosis of coal workers' pneumoconiosis. Dr. Zaldivar explained that the bullae present radiographically revealed emphysema. Dr. Zaldivar noted the inaccuracies in Claimant's smoking history. At his examination, the miner communicated to Dr. Zaldivar that he quit smoking in the 1980's. Dr. Zaldivar found that his smoking history was sufficient to cause bullous emphysema. Dr. Zaldivar also noted that the miner's low diffusion capacity was a result of emphysema. I find that Dr. Zaldivar provided adequate rationale for his finding of bullous emphysema as opposed to coal workers' pneumoconiosis. I further find that Dr. Zaldivar's opinion is supported by the objective evidence of record. Based on his qualifications and reasoned opinion, I find that Dr. Zaldivar's opinion is entitled to more weight than Drs. Ranavaya and Rao.

In addition to Drs. Altmeyer and Zaldivar, Dr. Crisalli also diagnosed bullous emphysema and found insufficient evidence to diagnosis coal workers' pneumoconiosis. Dr. Crisalli determined, despite the various inaccuracies, that Mr. Bryant has a very heavy smoking history. Dr. Crisalli related Claimant's breathing difficulties to his smoking history. Dr. Crisalli explained that the Miner's diminished breath sounds are consistent with emphysema. He also explained that the obstructed air flow and air trapping is typical of emphysema. Additionally, Mr. Bryant had reversibility with bronchodilators; which isn't seen with coal workers' pneumoconiosis. I find that Dr. Crisalli provided a persuasive rationale for his conclusion that Mr. Bryant does not have coal workers' pneumoconiosis. Dr. Crisalli supports his conclusion with objective test results. Based on his reasoned opinion, I find Dr. Crisalli's opinion is entitled to more weight than Drs. Ranavaya and Rao.

Dr. Rao submitted a letter stating that he treats Mr. Bryant for coal workers' pneumoconiosis, COPD, hypertension, colon cancer and coronary artery disease. Dr. Rao does not state what tests he performed or relied upon in making his determinations. No objective findings are attached to Dr. Rao's letter. Additionally, Dr. Rao notes 20 years of coal mine employment, more than double the amount of years I find, and no smoking history. I find that Dr. Rao's discrepancies regarding length of coal mine employment and smoking history significant in weighing his conclusion. I find that Dr. Rao has provided no support or rationale for his finding of coal workers' pneumoconiosis. Thus, I find that Dr. Rao's opinion is entitled to no weight.

Dr. Ranavaya performed the Department of Labor examination. Dr. Ranavaya concluded that the Claimant has pneumoconiosis and bullous emphysema. Dr. Ranavaya based his finding of coal workers' pneumoconiosis on an X-ray later interpreted by a dually-qualified physician as negative for pneumoconiosis. Dr. Ranavaya noted 22 years of coal mine employment and a ten-year smoking history. I found an eight-year coal mine employment history and over 30 years of smoking. I find that Dr. Ranavaya's opinion is based on an X-ray interpreted by a more qualified physician as negative, an inaccurate coal dust exposure and an inaccurate smoking history. Based on those findings, I find that Dr. Ranavaya's opinion is unreasoned and not supported by the objective evidence of record. As such, I accord little weight to Dr. Ranavaya's opinion.

In summary, I find the opinions of Drs. Altmeyer, Zaldivar and Crisalli to be well-reasoned and supported by objective evidence. I find Dr. Rao's opinion to be entitled to no

weight. I accord little weight to Dr. Ranavaya's opinion. Thus, I find that Mr. Bryant did not prove pneumoconiosis based on physician opinions submitted in the current claim for benefits.

The miner's five prior claims include physician opinions by Drs. Acosta, Altmeyer, Crisalli, Lesaca, Pelaez, Ranavaya, Rao, Rasmussen and Zaldivar.

Dr. Altmeyer reviewed both positive and negative chest X-ray interpretations. Dr. Altmeyer concluded that the X-ray films show typical changes of upper lobe pulmonary emphysema. Dr. Altmeyer also noted that the miner's low diffusing capacity is consistent with emphysema. Dr. Altmeyer's most recent findings are consistent with his findings in the prior claims. I find that Dr. Altmeyer provided a clear explanation of his finding and supported his finding with reference to objective evidence. Thus, I find his opinion entitled to more weight than Drs. Acosta, Ranavaya, Rao, Lesaca and Pelaez.

Dr. Zaldivar consistently concluded in the miner's prior claims and in the miner's current claim that the miner has bullous emphysema due to his lengthy smoking history. Dr. Zaldivar utilized objective testing to explain his finding. He explained that the miner's airway obstruction and low diffusing capacity display damaged lung tissue consistent with smoking induced emphysema. I find that Dr. Zaldivar provided a reasoned opinion. I find his opinion entitled to more weight than Drs. Acosta, Ranavaya, Rao, Lesaca and Pelaez.

Dr. Crisalli also did not find coal workers' pneumoconiosis. Based on objective testing, Dr. Crisalli found a mild obstruction to airflow. He noted cigarette smoking as the cause of such obstruction. I find that the results of Dr. Crisalli's examination are supported by the objective evidence of record. Based on his experience and reasoned opinion, I find his opinion entitled to more weight than Drs. Acosta, Ranavaya, Rao, Lesaca and Pelaez.

Dr. Acosta performed a 1987 Department of Labor examination of the miner. Dr. Acosta's qualifications are not in the record. Based on the objective testing performed during the examination, Dr. Acosta diagnosed coal workers' pneumoconiosis. Dr. Acosta found the miner to have only a ten year smoking history. Other than stating his finding, Dr. Acosta made no explanation of why he found pneumoconiosis. Other than stating the length of the miner's smoking history, Dr. Acosta made no statements on whether such smoking history would or would not cause his pulmonary impairment. Based on his unknown qualifications and lack of explanation, I find Dr. Acosta's opinion entitled to little weight.

Dr. Lesaca examined Mr. Bryant in 1973. His medical specialties are general practice and obstetrics and gynecology. Dr. Lesaca diagnosed pneumoconiosis and pulmonary emphysema. His diagnosis is based on a chest X-ray and pulmonary function study not included in the record. Due to the progressive nature of pneumoconiosis, I accord more weight to the more recent physician opinions of record than Dr. Lesaca's 1973 examination. I further find that Drs. Altmeyer, Zaldivar and Crisalli are more qualified in the area of pulmonary diseases than Dr. Lesaca. Thus, I find Dr. Lesaca's opinion entitled to little weight.

Dr. Pelaez submitted records from Logan Specialist Medical Clinic. His qualifications are not included in the record. Dr. Pelaez diagnosed pneumoconiosis and pulmonary emphysema. He lists the miner as smoking a ½ pack of cigarettes for "several years." It is unclear from the

medical records how Dr. Pelaez reached his conclusion regarding pneumoconiosis. I find that the medical records from Logan Specialist Medical Clinic do not provide a reasoned finding of pneumoconiosis. Based on the lack of explanation and detail, I find Dr. Pelaez's opinion entitled to little weight.

Dr. Ranavaya examined the miner for the Department of Labor in 1994. Dr. Ranavaya's qualifications are not in the record. Dr. Ranavaya diagnosed pneumoconiosis. He listed a 22-year coal mine employment and a ten year smoking history. Dr. Ranavaya made no statement regarding whether or not Mr. Bryant's smoking history caused any part of his pulmonary impairment. Dr. Ranavaya's length of coal mine employment and smoking history are inconsistent with my findings of coal mine employment and length of smoking. Other than stating that his conclusion is based on coal dust exposure and radiological evidence, Dr. Ranavaya made no explanation on why the objective evidence supports a finding of pneumoconiosis. As such, I find Dr. Ranavaya's opinion unreasoned and entitled to little weight.

Dr. Rao has submitted numerous letters on behalf of the claimant stating that he treats the claimant for pneumoconiosis. As explanation for his conclusion, Dr. Rao states that chest X-rays and CT scans have shown evidence of bullous emphysema. Drs. Altmeyer and Zaldivar have stated that Dr. Rao is incorrect in his interpretation that bullous emphysema equates with pneumoconiosis. Dr. Rao's qualifications are not in the record and he has provided no objective testing support for his conclusion. Based on the implication that Dr. Rao equates bullous emphysema with pneumoconiosis, I find his opinion entitled to little weight.

Dr. Rasmussen also diagnosed Mr. Bryant with pneumoconiosis. Dr. Rasmussen makes no statements regarding any smoking induced emphysema. However, when discussing the level of impairment, Dr. Rasmussen stated that Mr. Bryant's disability is due to cigarette smoking and coal dust exposure. Based on his lack of explanation, I find Dr. Rasmussen's opinion entitled to less weight than the opinions of Drs. Altmeyer and Zaldivar.

In summary, I find the opinions of Drs. Altmeyer, Zaldivar and Crisalli entitled to the most weight. I find the opinions of Drs. Acosta, Lesaca, Pelaez and Rao entitled to little, if any, weight. I find the opinions of Drs. Ranavaya and Rasmussen less persuasive than the opinions of Drs. Altmeyer, Zaldivar and Crisalli. After reviewing all the physician opinions of record, I find that Mr. Bryant has not proven coal workers' pneumoconiosis.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

After reviewing the chest X-ray evidence and physician opinions submitted in the miner's current claim for benefits, I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993). As noted below, I find Mr. Bryant has proven total disability and, thus, a material change in conditions. As such, a review of all the medical

evidence submitted in Mr. Bryant's prior claims has been reviewed. After weighing all the chest X-ray evidence and physician opinions together, I find that Mr. Bryant has not met his burden of proof in establishing the existence of pneumoconiosis.

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

In view of my finding that the existence of coal workers' pneumoconiosis has not been proven the issue of causation is moot. Moreover, as I have found that the miner has less than ten years of coal mine employment, he would not receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. The medical evidence discussed herein proves that any pulmonary impairment is due to the miner's lengthy smoking history.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[18] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and (v) lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

[18] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.,* 18 B.L.R. 1-9 (1993).

Four pre-bronchodilator and four post-bronchodilator pulmonary function studies were submitted in the miner's current claim for benefits. All eight studies produced qualifying results. Dr. Ranavaya's November 15, 2001 pre-bronchodilator and post-bronchodilator tests were found unacceptable by Dr. Gaziano. Thus, I find that the November 15, 2001 study is entitled to no weight. I further find that Mr. Bryant proved total disability based on six qualifying pulmonary function studies.

In the miner's five prior claims for benefits, eleven pre-bronchodilator and four post-bronchodilator pulmonary function studies were performed. Nine studies produced qualifying results and six studies produced non-qualifying results. Three of the qualifying results did not include tracings and, thus, do not conform to the regulations. Based on the varying results, I find that such pulmonary function studies neither preclude nor establish the existence of total disability. In reviewing all the pulmonary function studies of record, I find that the pulmonary function studies submitted in the current claim for benefits are the most persuasive in determining total disability. Thus, I find that the miner has proven total disability based on pulmonary function studies.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

Arterial blood gas studies performed on November 15, 2001, July 23, 2003 and November 24, 2003 were submitted in the miner's current claim for benefits. Dr. Zaldivar's July 23, 2003 exercise study produced qualifying results. No other study produced qualifying results. Dr. Zaldivar noted that exercise was stopped due to shortness of breath. Based on a majority of the studies producing non-qualifying results, I find that Mr. Bryant did not prove total disability by arterial blood gas studies.

Seven arterial blood gas studies were submitted in the miner's prior claim for benefits. None of the studies produced qualifying results. Thus, I find that such arterial blood gas studies do not prove total disability. After reviewing all the pulmonary function studies of record, I further find that Mr. Bryant did not prove total disability based on arterial blood gas studies.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element."

Mazgaj v. Valley Coal Company, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993).

As noted above, Drs. Crisalli, Altmeyer, Zaldivar, Rao and Ranavaya submitted opinions in the miner's current claim for benefits. Drs. Crisalli, Altmeyer, Zaldivar and Ranavaya agree that Mr. Bryant is totally disabled due to a pulmonary impairment. Dr. Rao stated that "the patient has moderate to severe chronic obstructive pulmonary disease." Although Dr. Rao did not state the miner is totally disabled, I find that his statement regarding severity equates to a finding of total disability. Based on the fact that all physicians of record agree that the miner is totally disabled due to a pulmonary impairment, I find that Mr. Bryant proved total disability by physician opinions.

The miner's five prior claims include physician opinions by Drs. Acosta, Altmeyer, Crisalli, Lesaca, Pelaez, Ranavaya, Rao, Rasmussen and Zaldivar. Drs. Lesaca, Rasmussen and Zaldivar found Mr. Bryant totally disabled due to some type of pulmonary impairment. Drs. Altmeyer, Crisalli, Ranavaya and Pelaez concluded that the miner was not totally disabled. Drs. Acosta and Rao did not state a determination of disability. As noted above, based on their unreasoned opinions, I find the opinions of Drs. Acosta, Lesaca, Pelaez and Rao entitled to little, if any, weight. Drs. Altmeyer, Crisalli, Ranavaya, Rasmussen and Zaldivar supported their conclusions regarding impairment with objective testing. Although a majority of the physician opinions did not find Mr. Bryant totally disabled, I find that, in regards to disability, the most recent physician opinions are entitled to the greatest weight.

I find that the miner's last coal mining positions required heavy manual labor. After reviewing the pulmonary function studies, the arterial blood gas studies and physician opinions submitted in the current claim, I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993). As the miner has proven total disability, he has also proven a change in condition of an applicable element of entitlement previously adjudicated against him. As such, a review of the evidence submitted in the miner's prior claims is warranted. After reviewing all the pulmonary function studies, arterial blood gas studies, and physician opinions of record, I find that the most recent evidence is most persuasive. Thus, I find Mr. Bryant has proven the existence of total disability.

E. Cause of total disability

The revised regulation, 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 799946 (Dec. 20, 2000).

Since I have found that the evidence of record fails to establish that Mr. Bryant suffers from coal workers' pneumoconiosis, I accordingly find that Mr. Bryant fails to establish that he suffers from a total respiratory disability due to pneumoconiosis.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has established that a material change in condition has taken place since the previous denial, because he is now disabled due to a pulmonary impairment. The claimant does not have pneumoconiosis, as defined by the Act and Regulations. The claimant is totally disabled. His total disability is not due to pneumoconiosis. He is therefore not entitled to benefits.

ORDER[19]

It is ordered that the claim of IKIE BRYANT for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[20]

[19] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[20] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.